**Joint Legislative Audit and Review Commission**
**of the Virginia General Assembly**

# Interim Report: Review of the Department of Medical Assistance Services

**Staff Briefing**
**December 10, 2001**

# Introduction



**Staff for this study:**

**Bob Rotz, Division Chief**

**Cindi Jones, Project Leader**

**Lisa Friel**

**Wendy Brown**

# Presentation Outline



- ☑ Introduction and Summary of Findings
- ☐ The Child Health Insurance Program
- ☐ The Mental Retardation Waiver Program
- ☐ Medicaid-Funded Non-Emergency Transportation Services
- ☐ Medicaid-Funded Pharmacy Services

# Study Mandate



- **SJR 441 from the 2001 General Assembly Session directed JLARC to conduct an evaluation of the development, management, utilization, and funding for the health and mental health services provided through the Department of Medical Assistance Services (DMAS).**
- **This resolution reflected a variety of concerns about the effectiveness and efficiency of DMAS' management of the Medicaid program and other State programs.**
- **A final report is required by November 30, 2002.**

# Virginia's Medicaid Program



- **In FY 2000, DMAS spent $2.7 billion to provide Medicaid-funded health and mental health services to more than 600,000 recipients, including children, pregnant women, and individuals who are aged, blind, or disabled.**

- **In spite of the fact that expenditures continue to grow, Virginia's Medicaid program expenditures per capita are 47$^{th}$ in the country.**

# Interim Report Reviews Four Programs



- **Four programs, administered by DMAS, were reviewed because they are in a period of transition, there are strong concerns about the management of the program, and/or because of escalating costs:**
  - **The Child Health Insurance Program**
  - **The Mental Retardation Waiver Program**
  - **Non-Emergency Transportation Services**
  - **Pharmacy Services**

# Study Issues



- **Is the DMAS revised system for providing health care services to uninsured children developed, managed, and funded in a manner that improves utilization of these services?**
- **Is the DMAS development, management, and funding of mental retardation services appropriate and adequate to address the needs of all Virginians eligible for these services?**
- **Is the DMAS development, implementation, and management of statewide brokerage services for non-emergency transportation services appropriate and adequate to provide quality transportation in a cost-effective manner?**
- **Are there additional improvements that DMAS could make to reduce the growing costs of prescription drugs covered under the Medicaid program?**

# Research Activities



- Structured interviews with State and federal staff, legislative staff, Medicaid providers and contractors, and major stakeholders for each study area.
- Site visits to the DMAS contractors for child health insurance and transportation, two former transportation pilot programs, and a local community service board.
- Survey of DMAS' Pharmacy Liaison Group, the Medical Society of Virginia, and the federal Pharmacy Technical Assistance Group.
- Comprehensive review of State, federal, and national documents on each of the program areas.
- Data on utilization, funding, and program data in all four areas.

# Summary of Study Findings



- **DMAS' development, implementation, and management of programs have been hindered to some extent by inconsistent direction from the leadership at DMAS. Since 1997, DMAS has had five different directors.**

- **Historically, DMAS has lacked clear, consistent, and timely communication with consumers, families, providers, and legislators. The General Assembly or the Secretary of Health and Human Resources has had to direct DMAS to seek outside input into its programs.**

# Summary of Study Findings: Child Health Insurance Program



- **Virginia's new program, Family Access to Medical Insurance (FAMIS) eliminated some obstacles to the former Children's Medical Security Insurance Program (CMSIP), but created new program design and operational issues.**
  - **4,000 former CMSIP children have dropped from FAMIS rolls since its inception; 1,617 families, representing approximately 2,400 children, will lose FAMIS coverage for failure to pay the initial premiums.**
  - **40 percent of families with children enrolled in FAMIS also have children enrolled in Medicaid, which causes families to have to access two totally different programs to obtain health care for all their children.**
- **Virginia has already forfeited $16 million in federal child health insurance dollars, and the federal government is currently determining how much of the unspent $68 million (FFY 1999 funds) we will be able to keep. Virginia is ranked 40$^{th}$ out 50 states for expenditures as a percent of the State's federal allotment.**

# Summary of Study Findings: Mental Retardation Waiver Program



- **The mental retardation waiver program has been in a state of flux for the last year and half because DMAS assumed State-level management of the MR waiver from the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). This was contrary to legislative intent.**

- **DMAS' decisions caused the denial or delay of needed MR waiver services, a lawsuit, and an ongoing investigation by the U.S. Office of Civil Rights.**

- **An underlying problem has been DMAS' poor communication with other State staff, task force members, consumers, and legislators.**

- **At the present time, there are 1,666 persons on the waiting list for MR waiver services and no waiver slots are available to serve them. The administration indicated that there would be 150 additional slots, but this has yet to occur.**

# Summary of Study Findings: Non-Emergency Transportation Services



- **DMAS' new transportation brokerage system appears to be an appropriate model for providing transportation services for Medicaid recipients to medical care appointments.**
- **It is estimated that the State will avoid projected cost increases of $56 million dollars over the next two years (difference between projected increases using historical data and contract costs).**
- **Implementation of the system in July 2001 was problematic because the contractor for the majority of the State was not ready. Some contract and operational problems remain.**
- **While DMAS should have delayed implementation until the contractors were ready, it is now addressing current concerns with the program.**

# Summary of Study Findings: Pharmacy Services



- **DMAS has in place most of the common strategies for controlling pharmacy costs, but many are less restrictive than other state Medicaid programs.**

- **Based upon a preliminary review of how DMAS' strategies compared with other state Medicaid programs, three improvements were identified:**
  - **Improve the prior authorization process for drugs,**
  - **Lower pharmacy reimbursement rates to reflect current market prices, and**
  - **Improve the recovery of third party payments.**

# Presentation Outline



- ☐ Introduction and Summary of Findings
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- ☐ Medicaid-Funded Pharmacy Services

# Virginia Has Lost Valuable Time in Its Development of Two Different Child Health Insurance Programs



- In 1997, prior to the federal plan, the General Assembly established a trust fund to extend health insurance to uninsured children of low-income families who were not eligible for Medicaid.
- Later in 1997, Congress passed the State Children's Health Insurance Program and authorized $40 billion in federal matching funds to all states for ten years. Virginia's allotment is $692 million and its enhanced match rate is 66 percent.
- In October 1998, DMAS implemented CMSIP, which was a Medicaid look-alike program. DMAS did not implement the legislative directive to also expand the Medicaid program to serve those families with incomes up to 150 percent of the federal poverty guidelines.
- In March 2000, the General Assembly passed legislation to create FAMIS, which is modeled after the private sector.
- In August 2001, FAMIS was implemented.

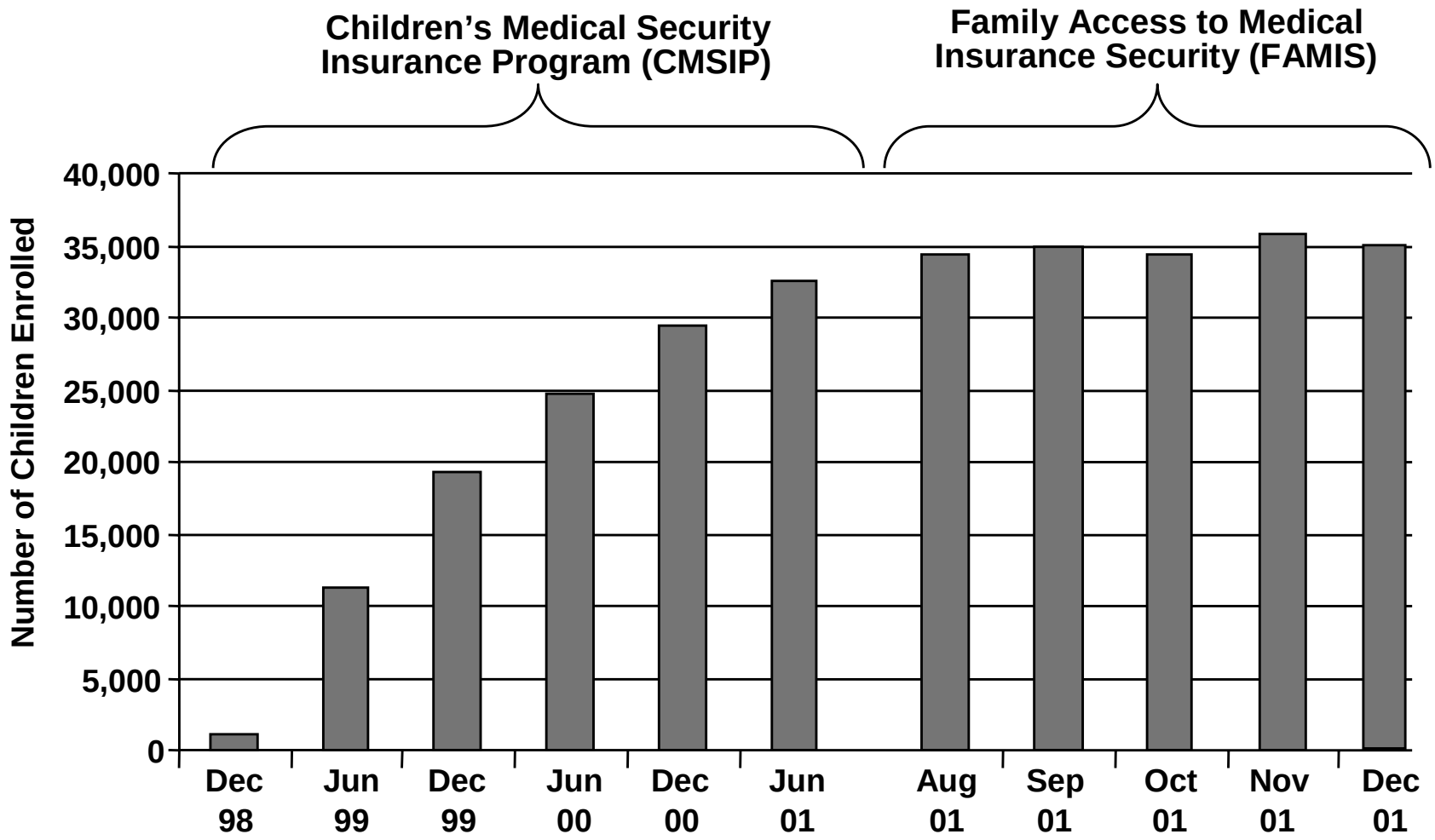
# FAMIS Is a Totally Different Program Than CMSIP



- **Resembles health insurance plans found in the the private sector. Under CMSIP, the plan was a Medicaid-look alike program.**
- **Establishes a central processing site for eligibility determination. Under CMSIP, the local departments of social services completed eligibility determination.**
- **Implements cost-sharing in the form of monthly premiums and co-payments. Under CMSIP, this was not required.**
- **Utilizes the State Employee Health Insurance package as a benchmark for health benefits. Under CMSIP, the benefit package was identical to Medicaid.**

# Child Health Insurance Enrollment Has Not Achieved the Goal of 63,200





# Former CMSIP Children Are Dropping from FAMIS



- **Since its inception in August 2001, more than 4,000 former CMSIP children were dropped from the FAMIS rolls for failure to return the annual applications for re-establishing eligibility.**

- **In December 2001, 1,617 families, representing approximately 2,400 children, will have their FAMIS canceled for failure to pay the first monthly premiums. This means that families will have to wait six months before they can reapply for FAMIS.**

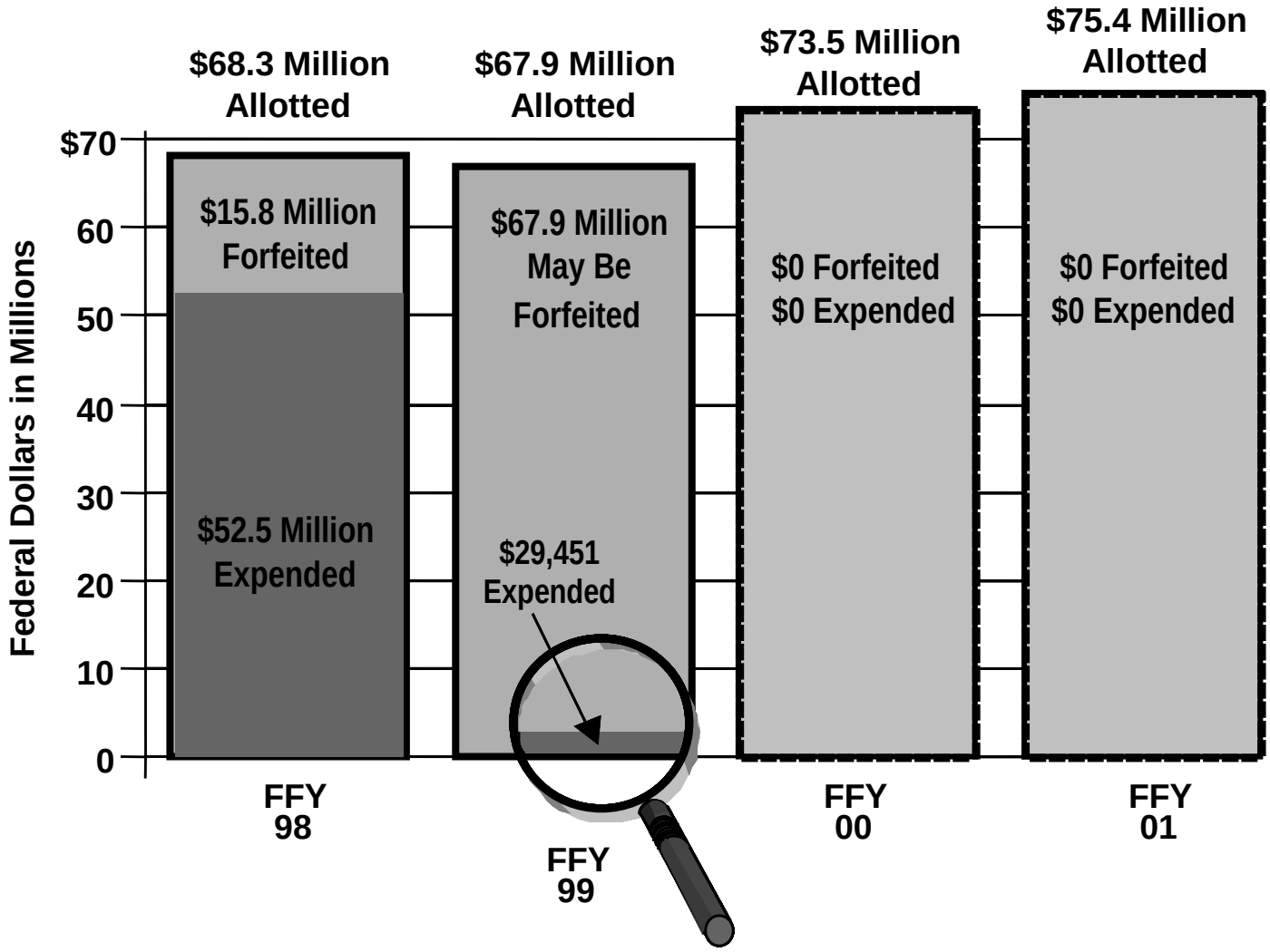
# Recommendation



- ***Recommendation*. DMAS, in conjunction with the FAMIS Outreach Oversight Committee, should develop a telephone and/or mail survey to track the reasons why children drop out of the FAMIS program. This survey should be conducted on an ongoing basis in order to provide State-level policy makers with the information necessary to determine the impact of the FAMIS program and policies on enrollment and retention of children in its health insurance program. The survey should include questions to determine whether the non-responses were due to moving, lack of interest in the program, increased income, confusion over administrative requirements, or new program requirements, such as co-payments, monthly premiums, or changes in health care benefits and providers.**

# Virginia Has Forfeited $16 Million, and for FFY 1999 Will Forfeit a Portion of $68 Million, in Federal Child Health Insurance Dollars





# The Federal Government Is Determining the Amount of FFY 1999 Funds to be Retained



- **According to federal staff, 17 or 18 states have overspent their FFY 1999 allotments for child health insurance.**
  - **These states will receive dollar-for-dollar payment for their over expenditures.**
  - **Funding for these costs will be provided from a pool of the unspent dollars of the other states, including Virginia's unspent dollars.**
- **Virginia will be able to retain some of its unexpended FFY 1999 funds and will be notified of the amount this week.**
  - **The amount is still to be determined, but it is expected to be less than the 64 percent retained for FFY 1998.**
  - **Virginia will only have one extra year (rather than the two years given for FFY 1998 unspent funds) to spend these funds.**

# Concerns with FAMIS: Central Processing Unit Is Experiencing Call Volume and Staffing Problems



- According to DMAS' request for proposals, the call volume was projected at 2,000 calls a month. Instead, it has been closer to 20,000 a month.
- The call center has experienced turnover of its management and call center staff.
- The consequence of this is potential or current FAMIS families are likely to communicate with call center staff that have not been adequately trained.
- Both DMAS and the contractor are addressing the staffing and training concerns.

# Concerns with FAMIS: Program Design Is Cumbersome for "Mixed Families"



| | Five Year Old Child Enrolled in Medicaid | Seven Year Old Child Enrolled in FAMIS |
|---|---|---|
| Point of Contact | Must contact local DSS for eligibility, enrollment, and questions; requires a Medicaid application and verification. | Must contact FAMIS Call Center for eligibility, enrollment and questions; requires a FAMIS application and verification. |
| Income Rule | Stepfather's income not counted. | Stepfather's income counted. |
| Doctor | Child is taken to Doctor A. | Child is taken to Doctor B. |
| Transportation | Transportation services provided. | Only emergency transportation services are provided. |

# Concerns with FAMIS: Program Design Is Cumbersome for "Mixed Families" (continued)



| Five Year Old Child Enrolled in Medicaid | Seven Year Old Child Enrolled in FAMIS |
|---|---|
| **Co-Payments** | |
| Co-payments not required. | Co-payments may be required. |
| **Premiums** | |
| Premium not required | $15 monthly premium may be required. |
| **Services Received** | |
| Receives all Medicaid-funded medical care services. | Receives only medical care services available to State employees, which include limits (such as mental health services) and require partial payment on selected services (such as braces). |

**Percent of Children Affected**

60% of children (20,520) are in families enrolled in FAMIS only. 40% of children (13,773) are in "mixed" families -- those enrolled in both FAMIS and Medicaid.

# Recommendations



- ***Recommendation.*** **The General Assembly may wish to direct DMAS to amend its Medicaid State Plan and regulations to adopt a single eligibility level of 133 percent of the federal poverty level for all children served in the Medicaid program. In addition, DMAS should be directed to make the necessary changes to the FAMIS State Plan to ensure that federal child health insurance funds (Title XXI) and not Medicaid funds (Title XIX) are utilized to fund this expansion.**

- ***Recommendation.*** **DMAS, in cooperation with the State Department of Social Services, should immediately develop a detailed plan to improve ongoing communication and coordination between the Medicaid and FAMIS programs. This plan should include provisions for a formal referral and tracking process between the programs, the designation of the roles and responsibilities of both staff for assisting families with enrollment and problem resolution, and dedicated staff within the Medicaid unit at the FAMIS call center that will assist with these coordination efforts.**

# Concerns with FAMIS: Several Issues Should Be Monitored to Gauge the Impact on Enrolling and Retaining Children



- Counting the step-parent's income for eligibility
- Using the best method to address fluctuating income for eligibility
- Requiring a six-month waiting period for insurance
- Requiring cost sharing, including monthly premiums and co-payments
- Reducing health benefits
- Implementing the Employer-Sponsored Health Insurance Program (ESHI)
- Ensuring outreach to uninsured children
- Implementing the FAMIS managed care delivery system

# Recommendation



- ***Recommendation.*** **DMAS should expand the quarterly report to the legislature concerning the status of FAMIS to include detailed tracking information on the enrollment and retention of children in FAMIS, the utilization and costs of mental health and health care benefits (those that have been reduced or expanded), how it is implementing the recommendations in this report, and the status of the issues highlighted in this report for ongoing monitoring.**

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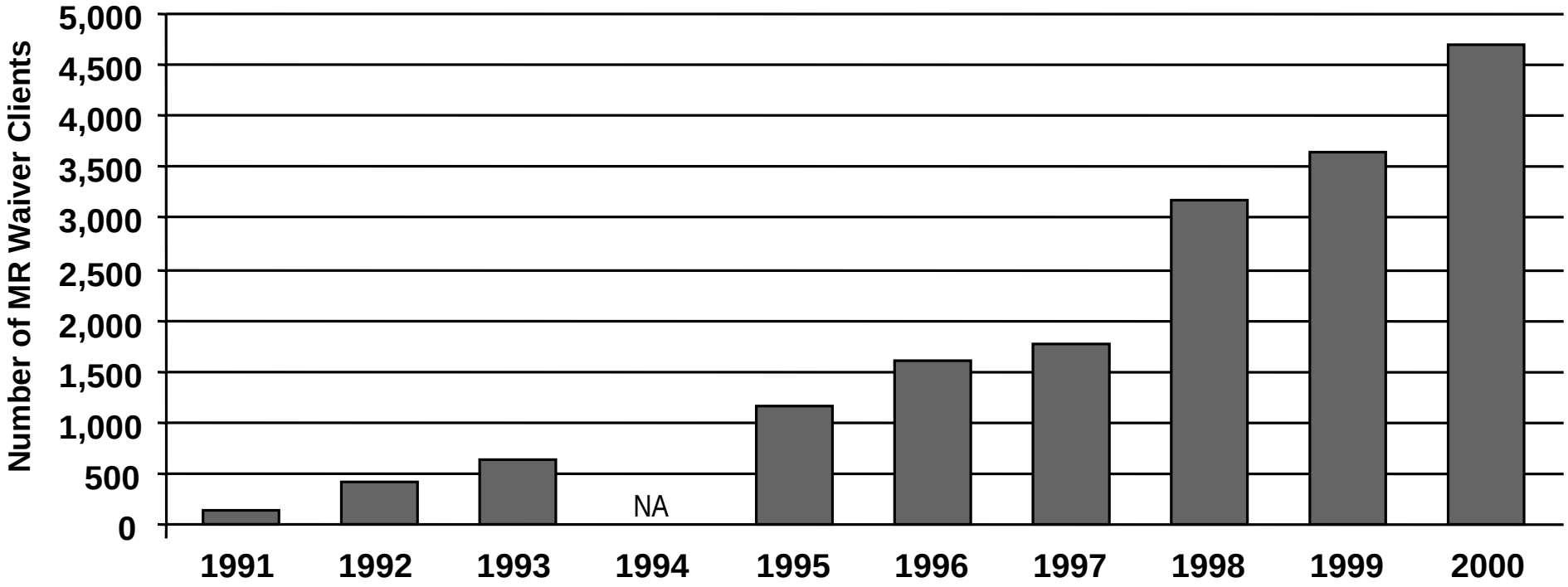
# Virginia Has Provided Mental Retardation Waiver Services Since 1991



- The MR waiver allowed the State to maximize federal dollars in order to address a statewide budget shortfall in the early 1990s.
- The mental retardation (MR) waiver provides a variety of community-based services to people with MR as an alternative to more costly institutionalization.
- To qualify for the MR waiver, individuals must be financially eligible for Medicaid services, have a diagnosis of mental retardation or be developmentally at risk if under age six, and need services at the ICF/MR level of care.
- These services have been managed at the State level by DMHMRSAS and DMAS. Services at the local level are managed through a network of 40 community service boards and 933 private providers.

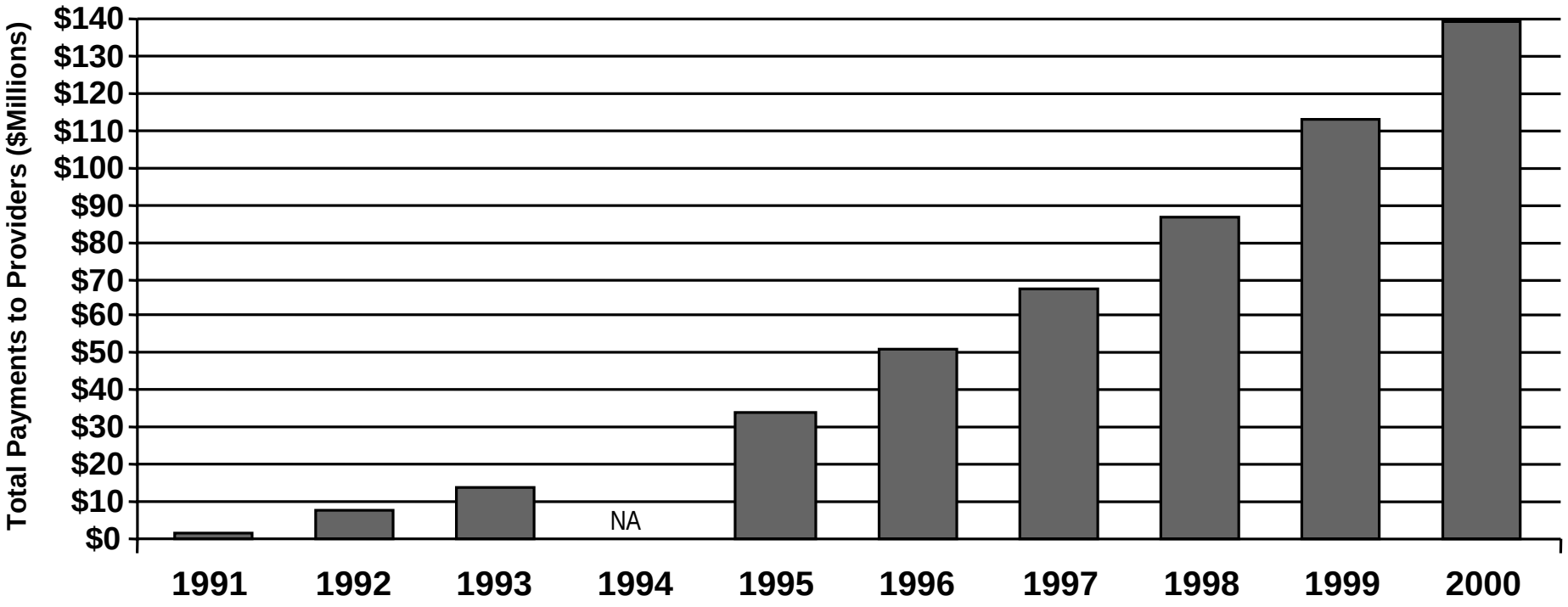
# The Number of MR Waiver Clients Has Increased Since 1991





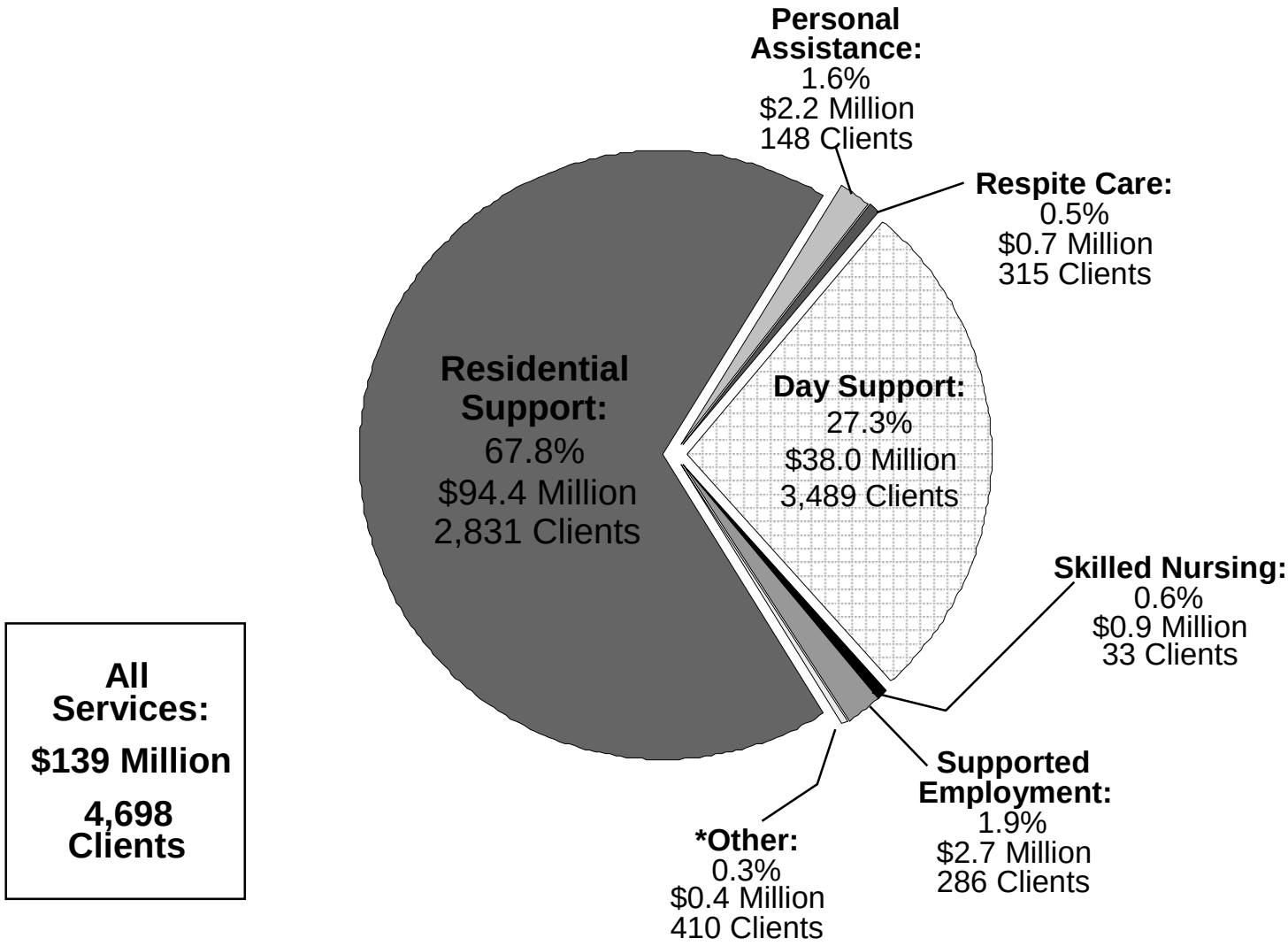
# Total Payments to Service Providers Have Increased





# Day Support and Residential Support Were the Most Frequently Used Services in FY 2000





# Legislative Actions Streamlined the Reimbursement Process for MR Waiver Services



- The 2000 General Assembly directed that all of the funds for MR waiver services should be managed by DMAS beginning on July 1, 2000 (for FY 2001).
- Prior to this direction, the reimbursement mechanism for allocating funds to the CSBs was a complicated stream of funds from both DMAS and DMHMRSAS.
- The transfer of funds was not as straightforward as envisioned, because there was a disagreement between the two State agencies concerning the adequacy of the amount of the funds transferred from DMHMRSAS to DMAS.

# DMAS Assumed Management of the MR Waiver and Made a Series of Missteps



- **The major outcome to this budget transfer was that DMAS determined that it was also going to assume the management of the MR waiver from DMHMRSAS. This was clearly not the legislative intent.**

- **Based upon DMAS' perception that the MR waiver funds were not enough to serve the current MR waiver clients, DMAS staff stopped all approvals for additional services for existing MR waiver clients and admissions to the waiver for new clients from June through mid-August 2000.**

- **This led to strong concerns raised by consumers, family members, providers, and legislators about the administration of the MR waiver.**

# DMAS Did Not Communicate Its Decisions Accurately and on a Timely Basis



- Once problems were identified, DMAS' communication to DMHMRSAS staff, families, service providers, and legislators concerning its decisions regarding requests for additional and emergency services was conflicting and slow.

- The denial of services and DMAS' subsequent handling of the problems led to a lawsuit that was recently settled out of court and an ongoing investigation by the U.S. Office of Civil Rights.

# DMAS Developed a New MR Waiver



- In October 2000, to address public concerns, the Secretary of Health and Human Resources announced the creation of a task force, led by DMAS, to develop a new MR waiver.

- While DMAS spent substantial amounts of time and resources on task force meetings and the development of a new MR waiver, it lost credibility when the emergency regulations and the provider manual contained errors and did not reflect perceived agreements by the task force members.

# DMAS Returned Management of Key Areas of the MR Waiver to DMHMRSAS and the CSBs



- According to the DMAS director, the major accomplishment with the MR waiver is that management of waiver slots was put back at the local level where it belongs.
- However, the management of the waiver slots was essentially at the local level prior to DMAS' assumption of management in July 2000.
- Despite DMAS transferring management of the waiver services and new admissions back to the CSBs and to DMHMRSAS, DMAS continues to micro-manage these activities.

# There are Currently at Least 1,666 People Waiting for MR Waiver Services



- DMAS and DMHMRSAS determined in September 2001 that the waiver had reached capacity – all 5,386 waiver slots were filled. The CSBs indicated that they did not want the management of the waiver slots under these conditions.

- To avoid additional discontent by consumers and families over the MR waiver, the administration announced in October 2001 plans to allocate $3.5 million and 150 new slots for the MR waiver. While DMAS initially said the new slots would be available immediately, as of December 1, 2001, the new slots have yet to become available.

- This means that since August 2001, only when clients were discharged from the MR waiver have there been slots available to meet the emergency needs of individuals on the waiting list.

# DMAS Has Taken Some Steps to Improve the Waiver But Concerns Remain



- **DMAS has taken some steps to improve the waiver, such as working with the task force to craft a new waiver, making the waiting list statewide, and establishing standardized waiting list criteria.**

- **However, concerns remain, including: the extent of communication DMAS staff will maintain with DMHMRSAS staff, CSB staff, task force members, consumers and providers in many areas including management of the waiver and the development of program policies and regulations; how the need for additional funds for waiver services will be projected and then distributed to the CSBs and DMHMRSAS; how much DMAS intervenes in the management of the waiver by DMHMRSAS and the CSBs; and, the timing of training for providers on new requirements and for families on accessing the new consumer directed services.**

# Recommendation



- ***Recommendation.*** **DMAS should provide a status report to the Health and Human Resources Subcommittees of the House Appropriations and Senate Finance Committees on the mental retardation waiver services by October 1, 2002. This report should address: (1) the status of program funding; (2) the number of available, filled, and planned waiver slots; (3) the development of a slot allocation methodology; (4) the number and characteristics of the clients on the MR waiver and the waiting lists; (5) the status of the CSBs' management of the waiver slots and waiting lists; (6) the status of DMHMRSAS pre-authorization of service enhancements and DMAS' audit of these approvals; (7) the current roles and responsibilities for DMAS, DMHMRSAS, and the CSBs; (8) the training provided to CSBs and other service providers on the MR waiver manual and regulations; (9) an update on Phase II activities, including changes to regulations, a long range plan for access to waiver slots, reimbursement rates, and the need for additional waiver services; and (10) an update on other outstanding concerns by the members of the Mental Retardation Waiver Task Force.**

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# Medicaid-Funded Non-Emergency Transportation Services



- Federal regulations require states to provide necessary transportation to and from the nearest qualified provider of Medicaid-covered services.
- All transportation services were reimbursed on a fee-for-service basis until 1995, when DMAS began enrolling some recipients in Health Maintenance Organizations (HMOs).
- Despite the decline in the fee-for-service recipient population with the shift to Medicaid HMO care and welfare reform, Medicaid transportation costs increased 20 percent annually in the past 10 years from $9.1 million to $54 million.

# Fraud and Abuse Contributed to Rising Medicaid Transportation Costs



- In the early 1990s, DMAS eliminated prior-authorization of transportation services.
- Without adequate oversight, fraud and abuse by transportation providers was alleged as a major cause of the cost increases.
- Examples of these types of fraud and abuse include claims for: a trip to a non-covered Medicaid service, more miles than the actual distance of the trip, multiple trips where only one trip was necessary, a trip that never occurred, and providing transportation in an ambulance when these higher cost services were not needed.
- DMAS could not provide data that suggests the level of fraud and abuse and the cost to the Commonwealth. The Medicaid Fraud Control Unit, located at the Attorney General's office, has convicted 38 providers and recovered $6.1 million since 1990.

# DMAS Initiated Two Pilot Programs to Address Growing Costs



- From April 1998 to July 2001, two pilot programs, managed by area agencies on aging in Southwest Virginia, conducted a trial of a transportation brokerage system. A brokerage system places a gatekeeper between the transportation provider and the recipient.
- These programs were successful in reducing fraud and abuse, thus saving the Commonwealth money.
- In addition to cost savings, the pilot programs provided DMAS with several best practices that could be implemented statewide.

# A Statewide Transportation Brokerage System Appears to Be an Appropriate Model



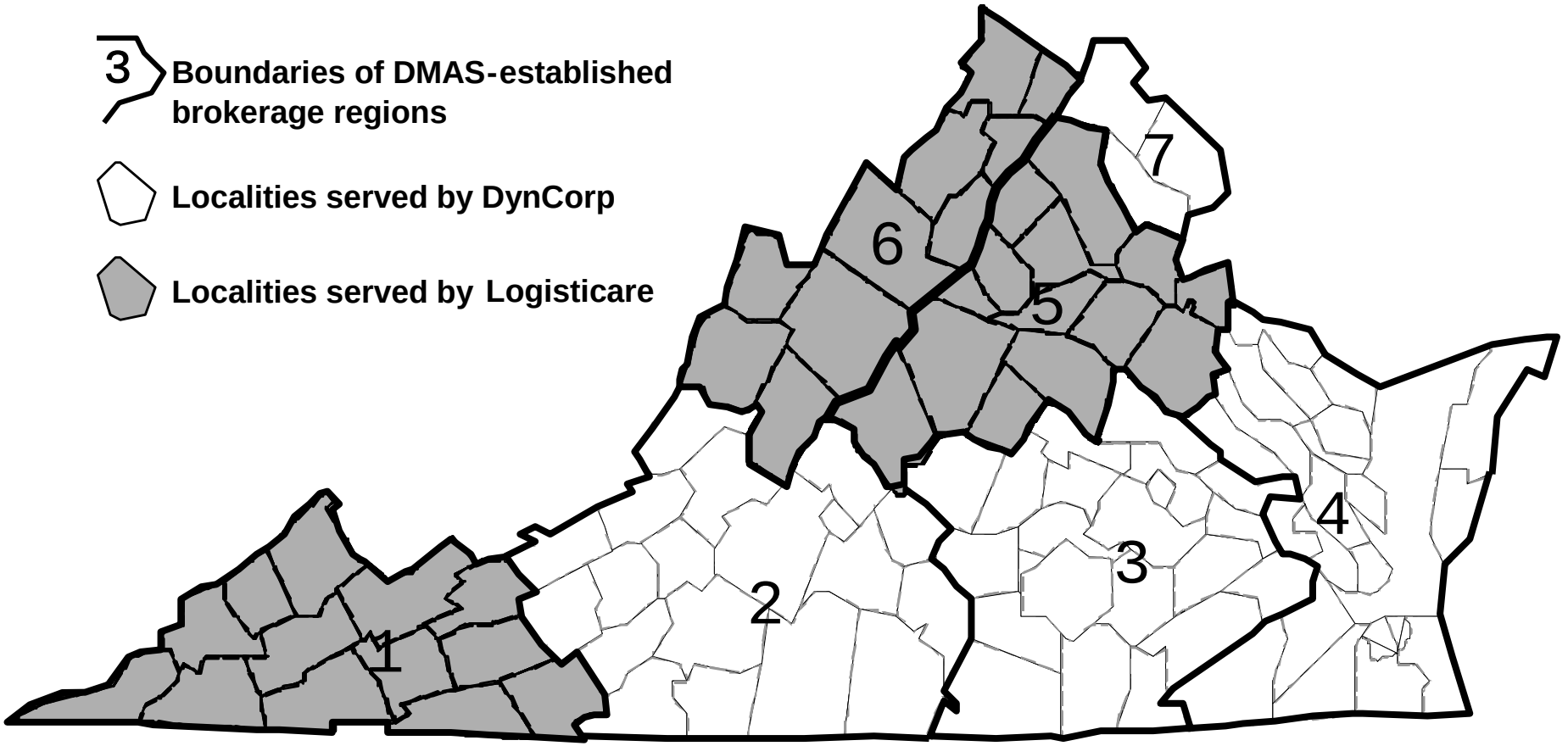
- Based on a 1997 report by the U.S. Office of the Inspector General recommending the use of a statewide brokerage system to control costs, the best practices of other states, and the success of two pilot programs, DMAS issued requests for proposals for statewide transportation brokerage services in 2000.

- Contracts were awarded to two national transportation brokerage companies, DynCorp and Logisticare, to provide transportation services for Medicaid's fee-for-service recipients.

- It is estimated that the state will avoid projected cost increases of about $56 million in FY 2002 and FY 2003 (difference between the projected increases using historical data and contract costs).

# For the Majority of the State, Service Responsibility Was Awarded to One Contractor





# Implementation of the New Transportation Brokerage System Was Problematic



- The transportation brokerage system was implemented on July 2, 2001.
- Most of the complaints were lodged against the contractor that was responsible for the majority of the State.
- Problems during implementation included:
  - Recipients not getting through or long waiting periods on telephone lines,
  - Recipients not getting picked-up or multiple transportation providers arriving for the same pick-up,
  - And lack of transportation providers.
- Problems occurred due to lack of preparation on the part of one contractor, DMAS' lack of an effective readiness review, and routine start-up problems.

# DMAS Did Not Effectively Review the Readiness of the Transportation Brokerage System



- During its readiness review two weeks prior to implementation, DMAS staff did not adequately address basic functions to ensure that the contractors had:
  - Adequate phone lines,
  - Sufficient transportation providers, and
  - Routine visits scheduled in the computer system.
- In addition, one contractor was also out of compliance with its contract for failure to have the necessary regional offices in place.
- DMAS should have delayed implementation of the new transportation system until these basic functions were in place.

# DMAS Took Several Actions to Correct Implementation Problems



- **Corrective actions taken by DMAS included:**
  - **Allowing recipients to resort back to fee-for-service transportation in one contractor's area until September 1, 2001;**
  - **Requiring daily phone calls with transportation contractors;**
  - **Issuing a "warning" letter to one contractor citing contract deficiencies;**
  - **Attending meetings with one contractor and service providers; and**
  - **Visiting the call centers and observing operations.**

# Status of the Medicaid Transportation Brokerage System



- **Progress of the transportation brokerage system:**
  - **Complaints are down to less than a half-of-one percent for the contractors**
  - **Additional transportation providers have been added**
  - **Transportation providers who are not meeting contract requirements, such as continual late pick ups, are removed from the contractor's network of providers**
  - **DMAS continues to monitor the brokerage system for contract compliance and recipient satisfaction**

# Status of the Medicaid Transportation Brokerage System
## (continued)



- **Remaining Problems:**
  - **Complaints remain regarding recipients who are not getting picked-up or who are picked-up late by transportation providers**
  - **CSBs and the contractors remain unclear about what transportation to certain day support services are covered**
  - **One contractor continues to not meet contract requirements**
- **Areas for DMAS to closely monitor:**
  - **Potential abuse of emergency transportation services, which are not managed by the contractors**
  - **Impact of projected 81,800 recipients shifting to Medicaid HMO plans in December 2001**
  - **A recipient satisfaction survey expected in early spring 2002, which should provide an assessment of the quality of transportation services provided**

# Recommendation



- ***Recommendation.*** **DMAS should provide a status report to the Health and Human Resources Subcommittees of the House Appropriations and Senate Finance Committees on Medicaid-funded non-emergency transportation services by October 1, 2002. This report should address: (1) contract compliance by the two brokerage firms; (2) the fiscal and program impact of the conversion of fee-for-service clients into managed care; (3) results of recipient surveys; (4) concerns of stakeholders and how they were addressed; (5) the impact the prior authorization for non-emergency transportation services has on the utilization and costs of emergency transportation services; and (6) the incidence of fraud and abuse for transportation services.**

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# Payment for Prescription Drugs Is an Optional Medicaid Benefit



- Even though prescription drug services are an optional Medicaid benefit, all states provide this coverage.
- Medicaid policy for prescription drug coverage is set by the individual states within broad federal guidelines.
- States do have the ability to control drugs costs through a variety of mechanisms, such as prescription limits, prior authorization, and lowering pharmacy fees.
- All cost alternatives, however, should be weighed against the impact that any restriction will have on the overall health care costs and access to drugs for Medicaid recipients.

# Virginia's Medicaid-Funded Prescription Drug Costs Continue to Grow



- There has been a 14 percent annual increase in expenditures in the past five years despite the decline in the fee-for-service recipient population.
- It was the third largest growing expenditure among DMAS programs behind managed care and mental health services in FY 2000.
- Drug costs account for 11 percent of the State's Medicaid budget in FY 2000.

# Several Factors Impact the Growth in Prescription Drug Expenditures



- The main factors impacting the growth in pharmaceutical expenditures are the development of new drug treatments, increased use of drugs, increased demand because of advertising by drug manufacturers, and the growth in the elderly and disabled population.

- Many of these factors are beyond the control of state Medicaid programs.

# Virginia's Medicaid Program Utilizes Several Common Cost Control Alternatives for Pharmacy Services, But More Can Be Done



- Many of Virginia's cost control measures are less restrictive than other state Medicaid programs. For example, Virginia does not have prescription limits (except for Viagra), does not actively utilize a prior authorization system, and pays more to pharmacies than the national average.

- DMAS has plans underway to expand its disease management program and to implement a two-tiered co-payment requirement.

# The Current Medicaid Prior Authorization Committee Is Ineffective



- **Medicaid federal regulations allow state Medicaid programs to implement prior authorization procedures; 35 states have active programs.**
- **In 1993, the General Assembly directed DMAS to create a Prior Authorization Committee and to implement a prior authorization process for high cost drugs.**
- **DMAS has found the statutory language is burdensome and unnecessary. It includes a dual public comment process and the requirement to notify drug manufacturers whose product is under review. Consequently, no drug requires prior authorization as a result of this process and the prior authorization committee has not met in several years.**

# Recommendation



- ***Recommendation.*** **The General Assembly may wish to amend Section 32.1-331.13-14 of the *Code of Virginia* to facilitate the creation and operation of a prior authorization program for selected drugs, including but not limited to: (1) the removal of the public hearing requirement and special notice to drug manufacturers, (2) the addition of members from the Drug Utilization Review Board to the Prior Authorization Committee, and (3) the addition of a provision stating that DMAS staff should be able to recommend potential drugs for the committee to review.**

# Virginia's Reimbursements to Pharmacies



- Reimbursements to pharmacies for newly developed drugs or drugs without a generic equivalents are determined by the lower of (1) the average wholesale price (AWP) (the sticker price set by the manufacturer) less a percentage, or (2) the Usual and Customary (U&C) charge to a cash paying customer.
- Virginia's AWP is AWP minus nine percent.
- In addition, Virginia reimburses pharmacies a dispensing fee of $4.25.

# DMAS Should Increase the Discount of the Reimbursement Rate to Pharmacies



| Reimbursement | Program | Entity |
|---|---|---|
| AWP minus 14% | HMO | National Average |
| AWP minus 10% | Medicaid | National Average |
| | | |
| AWP minus 12% | Medicaid | West Virginia |
| AWP minus 10% | Medicaid | Kentucky |
| AWP minus 10% | Medicaid | North Carolina |
| AWP minus 10% | Medicaid | South Carolina |
| AWP minus 9% | Medicaid | Virginia |

# Potential Cost Savings of Changing the AWP Discount Rate Paid to Pharmacies



| Rate Change from AWP Minus 9 Percent to: | Potential Savings: |
|---|---|
| AWP minus 10 percent | $4,551,407.67 |
| AWP minus 11 percent | $9,102,815.34 |
| AWP minus 12 percent | $13,654,223.01 |
| AWP minus 13 percent | $18,205,630.68 |
| AWP minus 14 percent | $22,757,038.35 |

# DMAS Should Also Consider Other Potential Methods for Reducing Pharmacy Reimbursement Rates



- One method is to utilize the Wholesale Acquisition Cost (WAC) instead of or in addition to the AWP rates. WAC is a more accurate determination of the actual price paid rather than the AWP, which is based on the suggested retail price set by the manufacturer.

- Six states use the Wholesale Acquisition Cost (WAC) instead of or in addition to AWP rates; these States add a percentage to the WAC to include the pharmacies' shipping and handling charges.

- Another method is to change the definition for Usual and Customary Rates. Virginia defines it as the price paid by a cash-paying customer (which tends to be high), rather than the best price paid by any other payer.

# Recommendations



- ***Recommendation.*** **The General Assembly may wish to direct DMAS to conduct a survey of Virginia pharmacies to determine the Average Wholesale Price (AWP) and the Wholesale Acquisition Cost (WAC) paid by Virginia pharmacies. DMAS should develop and implement a plan by July 1, 2002 to: (1) increase the AWP discount rate to more accurately reflect national averages, and (2) determine whether to incorporate or replace the AWP with the use of the WAC plus a percentage.**

- ***Recommendation.*** **The General Assembly may wish to direct DMAS to promulgate regulations by July 1, 2002 to change the definition for its Usual and Customary reimbursement rate to the lowest price pharmacists charge to any other payer.**

# Medicaid Third Party Payments For Pharmacy Costs



- Many recipients have pharmacy coverage through private health insurance or other State and federal programs, such as workmen's compensation or Medicare (this is referred to as third party coverage).
- Since Medicaid is payer of last resort, if a recipient has other insurance, then the third party payer is liable for claims sent to Medicaid.
- When claims involve a liable third party, state Medicaid programs can use the traditional cost avoidance system by returning the claim to the third party first for payment or a "pay and chase" system where they pay the claim and later recover the payment from the third party.

# DMAS Is Not Collecting $10 Million Annually in Third Party Payments



- Virginia, along with 35 other states, uses the pay and chase system for pharmacy claims. This method reduces the burden on the pharmacies to collect these payments.
- A recent report from the U. S. Office of the Inspector General found that over 30 pay and chase states, including Virginia, lost more than 80 percent of the Medicaid payments they tried to recover from third parties.
  - In 1999, Virginia paid and chased $11.9 million to third party payers, yet only recovered $1.5 million, for a loss of more than $10 million.
- States reported that the difficulty with payment recovery was due to denials from incompatible claim formats, unreasonable filing time limits, unprocessed claims with no explanation, vague denials, and the inability to identify the liable payer.

# Recommendation



- ***Recommendation.*** **The General Assembly may wish to direct the DMAS to examine its current method for recovering third party payments for pharmacy claims, including the cost feasibility for moving to a cost avoidance system. Based upon this review, DMAS should develop and implement a plan for improving third party payment recovery for pharmacy claims, to become effective by July 1, 2002.**